



U.S. Department of Veterans Affairs

Veterans Benefits Administration
Compensation Service

VSO and VSO Senior Leaders: Forms Automation Update

Briefed by:

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Compensation Service

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Background

- VBA continues to modernize our claims processes to provide faster and more efficient delivery of benefits to Veterans and their families, particularly during the time of the Novel Coronavirus (COVID-19) pandemic and state of emergency.
- Previously, VA did not have a standard form for these types of requests. Veterans, claimants, and Veterans Service Organizations (VSOs) had to submit such information on VA Form 21-4138, *Statement in Support of Claim* due to this gap in forms.
- VA is making it easier for Veterans/claimants to communicate their intent by providing specific forms for specific requests.
 - These changes allow greater use of computerized optical character recognition which is the automated processes to “read” forms for information upload – all of which are critical for faster processing and ultimately, faster delivery of benefits to claimants.
- VBA has created 5 new forms to be used in lieu of the current VA Form 21-4138, *Statement in Support of Claim*:
 - [VAF 20-10206 – FOIA/ Privacy Act Request](#)
 - [VAF 20-10207 – Priority Processing Request](#)
 - [VAF 20-10208 – Document Evidence Submission](#)
 - [VAF 20-10210 – Lay/Witness Statement](#)
 - [VAF 28-10212 – Ch 31 Request for Assistance](#)

VA Form 20-10206 FOIA/Privacy Act Request

- VA Form 20-10206 - FOIA/Privacy Act Request
 - 4-pages including instructions

**INFORMATION AND INSTRUCTIONS ON HOW TO SUBMIT
A FREEDOM OF INFORMATION ACT (FOIA) OR PRIVACY ACT REQUEST (PA)**

Please complete the attached form to submit a Freedom of Information Act (FOIA) or Privacy Act (PA) request. It must be signed by the requester or third-party authorized to act on behalf of the requester.

WHAT IS A FOIA REQUEST?

A FOIA request provides the public the right to request access to records from Federal agencies, except those protected by the nine FOIA exemptions. For additional information please visit <https://www.va.gov/FOIA/index.asp>.

WHAT IS A PA REQUEST?

A citizen of the United States or an alien lawfully admitted for permanent residence may request access to or amendment of records on herself/himself from a System of Records (SORs). Examples of PA records are personal Claims Files (C-File), educational loan, and beneficiary records. For additional information please visit <https://www.oprm.va.gov/privacy/>.

VERIFICATION OF IDENTITY AND CONSENT FOR PA REQUESTS ONLY

A request must include the following information:

- Your full name;
- Your date of birth;
- Your place of birth; *and*
- Your current mailing address.

Note: To help us locate requested records, please include your Social Security number (SSN) or Alien Registration number (A-number).

WHERE TO SEND YOUR REQUEST:

NOTE - All Privacy Act requests must be sent to the Centralized Support Division address listed below.

RECORDS CUSTODIAN	MAIL TO	ELECTRONIC SUBMISSION
<p align="center">Centralized Support Division (Claim Files)</p>	<p align="center">Department of Veterans Affairs Evidence Intake Center PO Box 4444 Janesville, WI 53547-4444</p>	<p align="center">EMAIL: FOIA.vbarmc@va.gov</p>
<p align="center">Veterans Benefits Administration (All other records)</p>	<p align="center">Department of Veterans Affairs Veterans Benefits Administration (20) 810 Vermont Avenue NW Washington, DC 24020</p>	<p align="center">EMAIL: FOIA.vbaco@va.gov</p>

SECTION VI: REQUESTER CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have completed this FOIA/PA request and declare it is true and correct to the best of my knowledge and belief.

20A. REQUESTER'S SIGNATURE (**REQUIRED**)

20B. DATE SIGNED

Month Day Year
 - -

SECTION VII: THIRD-PARTY CERTIFICATION AND SIGNATURE
 (Valid only if Section II has been completed and requester has an authorized third party)

I CERTIFY THAT the requester has authorized me as the undersigned representative and certifies that the truth and completion of the information contained in this document is to the best of the requesters knowledge and belief.

NOTE: A third-party signature **will not** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third Party* is of record or completed and attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

21A. THIRD-PARTY SIGNATURE

21B. DATE SIGNED

Month Day Year
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SECTION VIII: POWER OF ATTORNEY (POA) CERTIFICATION AND SIGNATURE
 (Valid only if Section II has been completed and requester has authorized POA representation)

I CERTIFY THAT the requester has authorized me as the undersigned representative and certifies the truth and completion of the information contained in this document to the best of the requesters knowledge and belief.

NOTE: A POA's signature **will not** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative* or VA Form 21-22a, *Appointment of Individual as Claimant's Representative* is of record or attached to this request.

22A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE)

22B. DATE SIGNED

Month Day Year
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PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: We need this information to identify and obtain the information you are requesting. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 5 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA Form 10207 Priority Processing Request

- VA Form 20-10207 - Priority Processing Request
 - 5 pages including instructions

PRIORITY PROCESSING REQUEST INSTRUCTIONS

Please complete the attached form to submit a request for priority processing of a claim due to certain circumstances or status as described below along with any supporting information or evidence.

If you are...	Then submit the following evidence if available or not already on file with VA...
<ul style="list-style-type: none"> Experiencing extreme financial hardship 	Documentation showing extreme financial hardship, including but not limited to the following: <ul style="list-style-type: none"> Copy of an eviction notice or statement of foreclosure Copy of notices of past-due utility bills Copy of collection notices from creditors
<ul style="list-style-type: none"> Terminally ill 	<ul style="list-style-type: none"> Copy of medical evidence showing illness that is terminal in nature, and/or If you want VA to get your private treatment records, submit a completed VA Form 21-4142, <i>Authorization to Disclose Information to the Department of Veterans Affairs</i>, and VA Form 21-4142a, <i>General Release for Medical Provider Information to the Department of Veterans Affairs</i>. NOTE: VA Forms are available at: www.va.gov/vaforms
<ul style="list-style-type: none"> Diagnosed with Amyotrophic Lateral Sclerosis (ALS) also known as Lou Gehrig's disease 	<ul style="list-style-type: none"> Copy of medical evidence showing ALS also known as Lou Gehrig's disease diagnosis, and/or If you want VA to get your private treatment records, submit a completed VA Form 21-4142 and VA Form 21-4142a
<ul style="list-style-type: none"> Very Seriously Injured/Ill or Seriously Injured/Ill during military operations (Defined as a disability resulting from a military operation that will likely result in discharge from military service.) 	<ul style="list-style-type: none"> Copy of military personnel records, such as a determination from the Department of Defense (DOD), and Medical evidence showing severe disability or injury, and/or If you want VA to get your private treatment records, submit a completed VA Form 21-4142 and VA Form 21-4142a
<ul style="list-style-type: none"> Age 85 or older 	<ul style="list-style-type: none"> Date of birth
<ul style="list-style-type: none"> Former Prisoner of War 	<ul style="list-style-type: none"> Copy of military personnel records such as DD Form 214, <i>Certificate of Release or Discharge from Active Duty</i>, or Information such as service number, branch and dates of service, dates and location of internment, detaining power, or any other information relevant to the detainment
<ul style="list-style-type: none"> Medal of Honor or Purple Heart Award recipient 	<ul style="list-style-type: none"> Copy of military personnel records such as DD Form 214, or Information showing receipt of Medal of Honor or Purple Heart Award

WHERE TO SEND INFORMATION AND EVIDENCE:

The time it takes your response to reach VA affects how long it takes us to process your request. We recommend calling our National Call Center at 1-800-827-1000 for immediate assistance whenever possible. If you are not a claimant or representative, we recommend mailing the information.

Note: You may designate one person or organization as a third-party representative to act on your behalf. A third-party may be a family member or other designated person who is not a Power of Attorney (POA), agent, or fiduciary. If you designate a third-party to represent you, a VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, must be attached or of record.

The **fastest** way to respond to VA is to contact us at 1-800-827-1000.

If you need to mail your correspondence, identify the benefit type; then, use the corresponding mailing address below:

MAILING ADDRESSES	
<p><u>Compensation Claims</u> Department of Veterans Affairs Compensation Intake Center P.O. Box 4444 Janesville, WI 53547-4444</p>	<p><u>Pension & Survivors Benefit Claims</u> Department of Veterans Affairs Pension Intake Center P.O. Box 5365 Janesville, WI 53547-5365</p>
<p><u>Board of Veterans' Appeals</u> Department of Veterans Affairs Board of Veterans' Appeals P.O. Box 27063 Washington, DC 20038</p>	<p><u>Fiduciary</u> Department of Veterans Affairs Fiduciary Intake Center P.O. Box 95211 Lakeland, FL 33804-5211</p>

These addresses serve **all United States and foreign locations.**

Attention: If you are currently receiving GI Bill Education benefits and are experiencing any of the reasons listed within Section III: Reason(s) for Request, please call the 1-888-GIBILL1 (1-888-442-4551) or send an email through Ask A Question at www.gibill.va.gov for immediate assistance.

IMPORTANT

If you or someone you know is in crisis, call the Veterans Crisis Line at 1-800-273-8255 and press 1, or visit <https://www.VeteransCrisis/line.net/> to chat online, or send a text message to 838255 to receive confidential support 24 hours a day, 7 days a week, 365 days a year.

Support for [deaf and hard of hearing](#) individuals is available.

VETERAN'S SSN - -

16C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?

- YES (If "YES," complete item 16D regarding your living situation) NO (If "NO," skip to item 17)

6D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION

- HOUSING WILL BE LOST IN 30 DAYS LEAVING PUBLICLY FUNDED SYSTEM OF CARE IN 30 DAYS OR LESS (e.g. homeless shelter)
 OTHER (Specify)

17. OTHER REASON(S)/CIRCUMSTANCES FOR REQUEST (Check all that apply)

- EXPERIENCING EXTREME FINANCIAL HARDSHIP TERMINALLY ILL MEDAL OF HONOR/PURPLE HEART RECIPIENT
 DIAGNOSED WITH AMYOTROPHIC LATERAL SCLEROSIS (ALS) ALSO KNOWN AS LOU GEHRIG'S DISEASE 85 YEARS OF AGE OR OLDER
 VERY SERIOUSLY INJURED/ILL OR SERIOUSLY ILL/INJURED (VSI/SI) DURING MILITARY SERVICE
 FORMER PRISONER OF WAR (Provide date(s) of confinement) (MM-DD-YYYY)

FROM	<input type="text"/> - <input type="text"/> - <input type="text"/>	TO	<input type="text"/> - <input type="text"/> - <input type="text"/>
FROM	<input type="text"/> - <input type="text"/> - <input type="text"/>	TO	<input type="text"/> - <input type="text"/> - <input type="text"/>

SECTION IV - REPORT OF MEDICAL TREATMENT
(If applicable)

18. LIST VA MEDICAL CENTERS (VAMC), DEPARTMENT OF DEFENSE (DoD) MILITARY TREATMENT FACILITIES (MTF), OR PRIVATE MEDICAL FACILITIES WHERE YOU WERE TREATED FOR THE CIRCUMSTANCE YOU IDENTIFIED IN ITEM 17 AND PROVIDE APPROXIMATE BEGINNING DATE OF TREATMENT:

<p>NAME/LOCATION OF TREATMENT FACILITY</p> <input type="text"/> <p>City</p> <input type="text"/> <p>State/Province</p> <input type="text"/> <p>Country</p> <input type="text"/>	<p>DATE OF TREATMENT (MM-DD-YYYY)</p> <input type="text"/> - <input type="text"/> - <input type="text"/>
<p>NAME/LOCATION OF TREATMENT FACILITY</p> <input type="text"/> <p>City</p> <input type="text"/> <p>State/Province</p> <input type="text"/> <p>Country</p> <input type="text"/>	<p>DATE OF TREATMENT (MM-DD-YYYY)</p> <input type="text"/> - <input type="text"/> - <input type="text"/>
<p>NAME/LOCATION OF TREATMENT FACILITY</p> <input type="text"/> <p>City</p> <input type="text"/> <p>State/Province</p> <input type="text"/> <p>Country</p> <input type="text"/>	<p>DATE OF TREATMENT (MM-DD-YYYY)</p> <input type="text"/> - <input type="text"/> - <input type="text"/>
<p>NAME/LOCATION OF TREATMENT FACILITY</p> <input type="text"/> <p>City</p> <input type="text"/> <p>State/Province</p> <input type="text"/> <p>Country</p> <input type="text"/>	<p>DATE OF TREATMENT (MM-DD-YYYY)</p> <input type="text"/> - <input type="text"/> - <input type="text"/>

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SECTION V - CERTIFICATION AND SIGNATURE

I CERTIFY THAT I have completed this form and it is true and correct to the best of my knowledge and belief.

18A. SIGNATURE OF REQUESTER **(REQUIRED)**

18B. DATE SIGNED (MM-DD-YYYY)

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**SECTION VI - THIRD PARTY SIGNATURE
(Only required if requester has an authorized third party)**

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A third-party signature **will not** be accepted unless a valid VA Form 21-0845, *Authorization to Disclose Personal Information to a Third-Party*, is of record or attached to this request. A third-party may be a family member or other designated person who is not a Power of Attorney, agent, or fiduciary.

19A. THIRD-PARTY SIGNATURE **(REQUIRED)**

19B. DATE SIGNED (MM-DD-YYYY)

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**SECTION VII - POWER OF ATTORNEY (POA) SIGNATURE
(Required only if requester has an authorized POA representation)**

I CERTIFY THAT the veteran/claimant has authorized me as the undersigned representative and certifies that the information contained in this document is true and complete to the best of the veteran/claimant's knowledge.

NOTE: A POA's signature **will not** be accepted unless a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual as Claimant's Representative*, is of record or attached to this request.

20A. POWER OF ATTORNEY (POA) SIGNATURE **(REQUIRED)**

20B. DATE SIGNED (MM-DD-YYYY)

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PENALTY: The law provides severe penalties (including fine and/or imprisonment) for willfully submitting any statement or evidence of a material fact you know to be false, or for fraudulent receipt of any document you are not entitled to.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations, 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is voluntary.

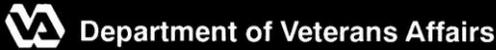
RESPONDENT BURDEN: This information will let us help you in support of or response to your claim. Title 38, United States Code, allows us to ask for this information. It should take you about 7 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid Office of Management and Budget (OMB) control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA Form 20-10208 Document Evidence Submission

- VA Form 20-10208 - Document Evidence Submission
 - 2 pages

VA Form 20-10210 Lay/Witness Statement

- VA Form 20-10210 - Lay/Witness Statement
 - 3 pages



VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

LAY/WITNESS STATEMENT

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at <https://iris.custhelp.va.gov>, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms.

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)	
<input type="text"/>	
2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)
<input type="text"/>	<input type="text"/>
4. DATE OF BIRTH Month Day Year	5. VA INSURANCE FILE NUMBER (If applicable)
<input type="text"/>	<input type="text"/>
6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)	
No. & Street <input type="text"/>	
Apt./Unit Number <input type="text"/> City <input type="text"/>	
State/Province <input type="text"/> Country <input type="text"/> ZIP Code/Postal Code <input type="text"/> - <input type="text"/>	
7. TELEPHONE NUMBER (Include Area Code)	8. E-MAIL ADDRESS <input type="checkbox"/> I agree to receive electronic correspondence from VA in regards to my claim.
<input type="text"/>	<input type="text"/>
Enter International Phone Number (If applicable)	

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION (Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)	
<input type="text"/>	
10. SOCIAL SECURITY NUMBER	11. VA FILE NUMBER (If applicable)
<input type="text"/>	<input type="text"/>
12. DATE OF BIRTH Month Day Year	13. VA INSURANCE FILE NUMBER (If applicable)
<input type="text"/>	<input type="text"/>
14. RELATIONSHIP TO VETERAN (Check all that apply)	
<input type="checkbox"/> SERVED WITH CLAIMANT <input type="checkbox"/> FAMILY/FRIEND OF CLAIMANT <input type="checkbox"/> COWORKER/SUPERVISOR OF CLAIMANT	
<input type="checkbox"/> OTHER (Specify) <input type="text"/>	
15. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)	
No. & Street <input type="text"/>	
Apt./Unit Number <input type="text"/> City <input type="text"/>	
State/Province <input type="text"/> Country <input type="text"/> ZIP Code/Postal Code <input type="text"/> - <input type="text"/>	

VA Form 10212 Chpt 31 Request for Assistance

- VA Form 20-10212 - Chapter 31 Request for Assistance
 - 2 pages

